Vaccinate before you Graduate

Immunization Screening Questionnaire

Print Your Teen's Information Below

LAST FIRST DATE OF BIRTH: (MONTH/DATE/YEAR) / / Male / Female (Please circle)

STREET ADDRESS APT #

CITY STATE ZIP CODE

Parent/Guardian: Please answer questions below to help us determine which vaccines may be given.	**Yes**	**No**	**Don't Know**
1. Does your child have allergies to medications, food, or any vaccine? **If yes, explain:**	☐	☐	☐
2. Has your child had a serious reaction to a vaccine in the past? **If yes, to what vaccine and when**:	☐	☐	☐
3. Has your child had a seizure or brain problem? **If yes, please indicate current status.**	☐	☐	☐
4. Does your child have leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5. Does your child take cortisone, prednisone, other steroids, or anticancer drugs, or had an x-ray treatment in the past 3 months?	☐	☐	☐
6. Has your child received a blood transfusion or blood products, or been given a medicine called immune (gamma) globulin in the past year?	☐	☐	☐
7. Has your child received any vaccinations in the past 4 weeks? **If yes, which vaccine**:	☐	☐	☐

PARENT/GUARDIAN: PLEASE PRINT YOUR NAME YOUR DAYTIME PHONE NUMBER

PARENT/GUARDIAN SIGNATURE